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State/Territory Name: Maine

State Plan Amendment (SPA) #:13-038

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

March 11, 2014

Mary Mayhew, Commissioner
Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011

Re: Maine SPA TN 13-038

Dear Commissioner Mayhew:

We are pleased to enclose a copy of approved Maine State Plan Amendment (SPA) No. 13-038 with an effective date of December 20, 2013. This SPA transmitted a proposed amendment to your approved Title XIX State plan to update eligibility criteria by adding Child and Adolescent Needs and Strengths (CANS) assessment to eligibility criteria for Targeted Case Management services.

If there are questions, please contact Joyce Butterworth at (617) 565-1220 or by e-mail at Joyce.Butterworth@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure/s

cc: Stephanie Nadeau, Director, Office of Maine Care Services

OFFICIAL

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 13-038

2. STATE: Maine

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
Centers for Medicare and Medicaid Services
Department of Health and Human Services

4. PROPOSED EFFECTIVE DATE
~~November 20, 2013~~ December 20, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.80

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 cost neutral
b. FFY 2015 cost neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplemental to Attachment 3.1-A pages ~~TBD~~
Page 1a-1f; Page 2a-2d; Page 3a-3f; Page 4a-4f; Page 5a-5e; Page 6a-6f

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Supplemental to Attachment 3.1-A pages ~~TBD~~
Pages 4g through 4k

10. SUBJECT OF AMENDMENT:
Targeted Case Management Services

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Commissioner, Dept. of Health and Human Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME:
Mary C. Mayhew

14. TITLE:
Commissioner, Department of Health and Human Services

15. DATE SUBMITTED:
12-20-13

16. RETURN TO:

Stefanie Nadeau
Director, MaineCare Services
#11 State House Station
242 State Street
Augusta, Maine 04333-0011

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 20, 2013

18. DATE APPROVED:
March 11, 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
December 20, 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Richard R. McGreal

22. TITLE:
Associate Regional Administrator
Division of Medicaid & Children's Health Operations, Boston, MA

23. REMARKS:
Maine requests pen & ink changes to:

reflect an effective date of 12/20/2013 due to tribal notification and implementation delay; and

include pagination specifications.

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TARGETED CASE MANAGEMENT SERVICES

[Children with Chronic Health Conditions]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Children with Chronic Health Conditions must meet the following criteria:

Eligibility Criteria for Children with Chronic Medical Conditions

1. A child who is infected with the human immunodeficiency virus (HIV), as determined by a positive HIV antibody or antigen test, or who has a diagnosis of HIV disease or AIDS;
   OR
2. A child who has:
   a. been diagnosed with an autoimmune disease, diabetes, respiratory disorder, a neurological disorder, brain injury or other chronic condition specifically recognized by the Department or its authorized agent;

AND

three (3) or more documented functional limitations, including:

Vocational
Impairment in vocational functioning as manifested by (1) an inability to be consistently employed at a self-sustaining level or (2) an ability to be employed only with extensive supports.

Education
Impairment in educational functioning as manifested by an inability to establish and pursue educational goals within a normal time frame or without extensive supports.

Instrumental Activities of Daily Living (IADL)
Impairment in IADL functioning as manifested by an inability to consistently and independently accomplish home management tasks, including household meal preparation, washing clothes, grocery shopping and budgeting.

Social or Interpersonal
Impairment in social or interpersonal functioning as manifested by an inability to independently develop or maintain social relationships, or to independently participate in social or recreational activities.

Community
Impairment in community functioning as manifested by a pattern of significant community disruption, including family disruption or social unacceptability or inappropriateness.

Self-care, Independent Living or Activities of Daily Living
Impairment in self-care or independent living as manifested by an inability to consistently perform the range of practical daily living tasks required for basic functioning in the community, including:

- Bed mobility, transfer, locomotion, eating, toilet use, bathing, and dressing
- Grooming, hygiene, and meeting nutritional needs

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TARGETED CASE MANAGEMENT SERVICES

[Children with Chronic Health Conditions]

- Care of personal business affairs
- Transportation and care of residence
- Procurement of medical, legal, and housing services
- Recognition and avoidance of common dangers or hazards to self and possessions.

;

OR

3. A Child who has:
   a. a diagnosed physical condition or the presence of a documented history by a professional approved by the Department of prenatal, perinatal, neonatal, or early physical developmental events or conditions suggestive of damage to the central nervous system or of later atypical physical development, such as, but not limited to, cerebral palsy, meningitis, heart defects, or bronchiopulmonary dysplasia which, without intervention, has a high probability of resulting in physical developmental delay,

AND

   b. significant impairment or limitation in adaptive functioning according to criteria as established by the Department and determined by a qualified professional approved by the Department.

☒ Target group Includes individuals transitioning to a community setting and are consistent with all federal guidelines. Case-management services will be made available for up to 30 days consecutive days of a covered stay In a medical Institution. Reimbursement is made to community-based case managers and not the medical institution for this service. The target group does not include Individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL). July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
☒ Entire State
☐ Only in the following geographic area [**Specific areas]**

Comparability of services (§§1902(a)(10)(B)and 1915(g)(1))
☐ Services are provided in accordance with §1092(a)(10)(B) of the Act.
☒ Services are not comparable in amount duration and scope (§1915(g)(1))

Definition of Services (42 CFR 440.169): Definition of services 42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, In gaining access to needed medical, social, educational and other services. Targeted Case Management Includes the following assistance

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TARGETED CASE MANAGEMENT SERVICES

[Children with Chronic Health Condition]

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

The comprehensive assessment must be completed within the first thirty (30) days of Initiation of services and reassessment must minimally occur on an annual basis (or as a change in the member's needs occur).

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational , and other services needed by the Individual;
  - Includes activities such as ensuring the active participation of the eligible Individual, and working with the Individual (or the Individual's authorized health care decision maker) and others to develop those goals; and
  - Identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible Individual obtain needed services including
  - activities that help link the Individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities are consistent with federal regulations and include:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible Individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary. **Plans must be monitored at least every 90 days, or as the member's needs change and any change in the plan must be documented in the member's file.** Monitoring will be conducted to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan.

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[Children with Chronic Health Conditions]

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

☒ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible Individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(v) and 42 CFR 441.18(b)):
Provider qualifications are as follows:

Staff Qualifications
Comprehensive Case Manager Qualifications

a. Staff must have a minimum of a:
   1. Bachelor's Degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing or closely related field,
      OR
   2. Graduate of an accredited graduate school with a Master's Degree in social work, education, psychology, counseling, nursing or closely related field,
      OR
   3. Bachelor's Degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one (I) year of full-time equivalent relevant human services experience,
      OR
   4. Staff who were employed at the time this rule goes into effect (8/112009) as a case manager providing services under the former subsections will be considered qualified.

Freedom of choice 42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an Individual's free choice of providers In violation of section 1902(a)(23) of the Act.

1. Eligible Individuals will have free choice of any qualified Medicaid provider within the specified geographic area Identified In this plan.
2. Eligible Individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

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[Children with Chronic Health Conditions]

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

☐ Target group consists of eligible Individual with developmental disabilities or with chronic mental Illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that Individuals with developmental disabilities or with chronic mental illness receive needed services: **[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3). 42 CFR 441.18(a)(6):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an Individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entitles under other program authorities for this same purpose.

Case Records 42 CFR 441.18(a)(7)):

Providers maintain case records that document for all Individuals receiving case management as follows: (i)The name of the Individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified In the care plan have been achieved; (v) Whether the Individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and Inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) Is not available In expenditures for, services defined in §440.169 when the case

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[Children with Chronic Health Conditions]

management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible Individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation ; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an Individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

[Specify any additional limitations.]

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TARGETED CASE MANAGEMENT SERVICES

[Members Experiencing Homelessness]

Target Group 42 Code of Federal Regulations 441.1818)(1) and 441.1819)):

Members Experiencing Homelessness must meet the following criteria:
Members experiencing homelessness must meet the following Eligibility Criteria to be eligible for TCM under this Section.
A member who;

1. currently resides or has in the past ninety (90) days resided in an emergency shelter in the State of Maine,
   OR
2. does not otherwise have a permanent address, residence, or facility in which they could reside,
   AND
3. requires treatment or services from a variety of agencies and providers to meet the individual's medical, social, educational, and other needs,
   AND
4. will access needed services only if assisted by a qualified targeted comprehensive case manager who, in accordance with the individual plan of care, locates, coordinates, and regularly monitors the services.
5. Additionally members experiencing homelessness must meet one or more of the following criteria to be eligible for TCM under this section;
   a. is in need of immediate medical care, OR
   b. is in need of an immediate crisis evaluation or mental health assessment to address a behavioral health issue, OR
   c. has a current. medical or mental health condition and is at risk of losing or has lost access to medically necessary services, OR
   d. has an immediate need for medications to address an existing medical and/or behavioral health condition, OR
   e. is demonstrating physical or mental impairment such that services are necessary to improve, restore or maintain health and well-being, OR
   f. has experienced immediate or recent trauma and is demonstrating a need for assistance with gaining and coordinating access to necessary care and services appropriate to their needs.

☒ Target group includes individuals transitioning to a community setting and are consistent with all federal guidelines. Case-management services will be made available for up to 30 days consecutive days of a covered stay in a medical institution. Reimbursement is made to community-based case managers and not the medical institution for this service. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or Individual between ages 22 and 64 who are served in Institutions for Mental Disease or Individuals

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[Members Experiencing Homelessness]

who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)
Areas of State in which services will be provided (§1915(g)(1) of the Act):

☒ Entire State
___ Only in the following geographic areas: **[Specify areas]**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
☒__ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

The comprehensive assessment must be completed within the first thirty (30) days of initiation of services and reassessment must minimally occur on an annual basis (or as a change in the member's needs occur).

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including

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[Members Experiencing Homelessness]

3. Bachelor's Degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one (1) year of full-time equivalent relevant human services experience,
OR
4. Staff who were employed at the time this rule goes into effect (8/1/2009) as a case manager providing services under the former subsections will be considered qualified.

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified In this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception §1915(g)(1) and 42 CFR 441.18(b)):
☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental Illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental Illness receive needed services: **[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that Individuals within the target groups receive needed services.]**

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7))

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[Members Experimenting Homelessness]

Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified In the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not Include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) Is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible Individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that Is included In an Individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Services are provided to homeless individuals following a determination of medical need. The services are provided to homeless Individuals who require multiple services to meet multiple assessed needs and they have services that are considered necessary to prevent, alleviate, prevent worsening of or correct conditions that endanger life, cause suffering or pain, result in illness, or interfere with a person's capacity for normal activity.

[Specify any additional limitations.

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[Children with Behavioral Health Disorders]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Children, ages birth through 20 with behavioral health disorders. The specific eligibility requirements are as follows:
Children must meet the criteria listed below in subsections I OR 2. In addition children must meet the criteria listed in subsection 3 to be eligible for TCM Services.

1. A child with a completed multi-axial evaluation of an Axis I or Axis II mental health diagnosis(es) as described in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or a diagnosis described in the most recent version of the Diagnostic Classification of Mental Health and Developmental Disabilities of Infancy and Early Childhood (DC: 0-3). Axis I mental health diagnoses do not include the following: Learning Disabilities (LD) in reading, mathematics, written expression, Motor Skills Disorder, and LD NOS (Learning Disabilities Not Otherwise Specified); Communication Disorders (Expressive Language Disorders, Mixed Receptive Expressive Language Disorder, Phonological Disorder, Stuttering, and Communication Disorder NOS);
   OR
2. A child between birth and five (5) years of age who:
   a. is determined by a professional approved by the Department as being at risk of developing a mental health disorder due to known environmental or biological risks using DHHS adopted tools,
   AND
   b. has significant impairment or limitation in adaptive behavior or functioning according to criteria as established by the Department and determined by a qualified professional approved by the Department.

3. Level of Care Criteria for services will be assessed using either the Children and Adolescent Functional Assessment Scale (CAFAS) - a multi-dimensional rating scale, which assesses a member's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems or Child and Adolescent Needs and Strengths (CANS) - a multipurpose tool that assesses the needs and strengths of children and adolescents with mental illness, developmental disabilities/intellectual disabilities, and autism spectrum disorders.

   ❖ Level of care criteria for services assessed through CAFAS:
   a. Case management service is authorized for up to thirty (30) days from the date of the first billed encounter if the eight (8) scale composite CAFAS score is fifty (50) or less.
   b. Case management services may continue beyond thirty (30) and up to ninety (90) days from the date of the first billed encounter if the eight (8) scale composite CAFAS score is at least between fifty-one (51) and seventy (70).
   c. Clinical information will be considered in addition to the composite CAFAS scores above as the scores are not the sole criteria for eligibility and review.

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[Children with Behavioral Health Disorders]

d. Case management services may continue if the 8 scale CAFAS score is above seventy (70). Service continuation will be dependent upon clinical information submitted.

❖ Level of care criteria for services assessed through the CANS:
   a. Case management service is authorized for up to ninety (90) days from the date of the first billed encounter if the assessment scores are 2 or higher for both the "Behavioral/Emotional needs" AND "Life Domain Functioning" sections of the CANS-PC, the CANS-MH or the CANSAT-MH.
   b. Clinical information will be considered in addition to the CANS scores as the scores are not the sole criteria for eligibility and review.
   c. Case management service may continue beyond ninety (90) days dependent on clinical information submitted.

☒Target group includes Individuals transitioning to a community setting and are consistent with all federal guidelines. Case-management services will be made available for up to 30 days consecutive days of a covered stay in a medical institution. Reimbursement is made to community-based case managers and not the medical institution for this service. The target group does not include individuals between ages 22 and 64 who are served In Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
☒ Entire State
☐ Only In the following geographic areas: [Specify areas]

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1)
☐ Services are provided in accordance with §1902(a)(10)(B) of the Act.
☒ Services are not comparable In amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, In gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
   - taking client history;
   - Identifying the individual's needs and completing related documentation; and

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[Children with Behavioral Health Disorders]

- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

The comprehensive assessment must be completed within the first thirty (30) days of initiation of services and reassessment must minimally occur on an annual basis (or as a change in the member's needs occur).

❖ Development (and periodic revision) of a specific care plan that is based on the Information collected through the assessment that
- specifies the goals and actions to address the medical, social, educational, and other services needed by the Individual;
- Includes activities such as ensuring the active participation of the eligible Individual, and working with the individual (or the Individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible Individual;

❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including

- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified In the care plan; and

❖ Monitoring and follow-up activities are consistent with federal regulations and include:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible Individual's needs, and which may be with the individual, family members, service providers, or other entitles or individuals and conducted as frequently as necessary. **Plans must be monitored at least every 90 days, or as the member's needs change and any change in the plan must be documented in the member's file.** Monitoring will be conducted to determine whether the following conditions are met:
  - services are being furnished In accordance with the individual's care plan;
  - o services in the care plan are adequate; and
  - changes in the needs or status of the Individual are reflected in the care plan.

Monitoring and follow-up activities Include making necessary adjustments in the care plan and service arrangements with providers.

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[Children with Behavioral Health Disorders]

☒ Case management Includes contacts with non-eligible individuals that are directly related to identifying the eligible Individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible Individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualification of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Provides qualifications are as follows:

Staff Qualifications

Comprehensive Case Manager Qualifications

a. Staff must have a minimum of a:
   1. Bachelor's Degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, or nursing or closely related field,
      OR
   2. Graduate of an accredited graduate school with a Master's Degree on social work , education, psychology, counseling, nursing or closely related field,
      OR
   3. Bachelor's Degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one (I) year of full-time equivalent relevant human services experience,
      OR
   4. Staff who were employed at the time this rule goes into effect (8/1/2009) as a case manager providing services under the former subsections will be considered qualified.

Freedom of choice (42 CFR 441.18(a)(1)
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible Individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

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TARGETED CASE MANAGEMENT SERVICES

[Children with Behavioral Health Disorders]

☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental Illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental Illness receive needed services: **[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

Access to Services 42 CFR 441 .18(a)(2) 42 CFR 441. 18(a)(3). 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an Individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all Individuals receiving case management as follows: (i)The ·name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (Iv) The nature, content, units of the case management services received and whether goals specified In the care plan have been achieved; (v) Whether the Individual has declined services In the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not Include, and Federal Financial Participation (FFP) Is not available In expenditures for services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not

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[Children with Behavioral Health Disorders]

available In expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services If there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational , or other program except for case management that is Included in an individualized education program or Individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

[Specify any additional limitations.]

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TARGETED CASE MANAGEMENT SERVICES

[Members with Developmental Disabilities]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441. 18(g)):

Adults with Developmental Disabilities must meet the following criteria:

An individual is eligible for case management services if he or she is age eighteen (18) or older and meets the eligibility requirements of Title 34B M.R.S.A.§3573, which defines developmental disabilities, or Title 34B M.R.S.A. §6002, which defines autism. A person who has reached his or her eighteenth (18th) birthday and is under age twenty-one (21) may choose to receive case management services as an adult.

Children with Developmental Disabilities must meet the following criteria:

Acceptable standardized instruments means, for developmental disabilities, CHAT (ages 6 through 20), Vineland Adaptive Behavior Scales (up through age 20), Battelle Developmental Inventory (up through age 7), Bayley Scales of Infant and Toddler Development (age 1 month through 2 years), and Ages and Stages (and Ages and Stages Social Emotional scales) (up through age 5).

Children must meet the criteria listed below in subsection 1 OR 2 OR 3. In addition, children must meet the criteria listed in 4 to be eligible for TCM Services.

1. Meet the definition of developmental disabilities as defined in 22 M.R.S.A. §3573 or have an Axis II diagnosis of mental retardation as described in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders;
   OR
2. Have an Axis I diagnosis of pervasive developmental disorder as described in the most recent Diagnostic and Statistical Manual of Mental Disorders;
   OR
3. For children between birth and five (5) years of age:
   a. Are determined by a professional approved by the Department as being at risk of developing a Pervasive Developmental Disorder due to known environmental or biological risks using DHHS adopted tools,

   AND

   b. Have significant impairment or limitation in adaptive behavior or functioning according to criteria established by the Department (See Section 13.03-2(B)) and as determined by a qualified professional approved by the Department.
4. Level of Care Criteria for services assessed through the CHAT:
   a. Case management service is authorized for up to thirty (30) days from the date of the first billed encounter if the CHAT score is twenty (25) or less.

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b. Case management services may continue beyond thirty (30) days and up to ninety (90) days from the date of the first billed encounter if the CHAT score is at least between Twenty-six(26) and thirty-five (35).
c. Clinical information will be considered in addition to the CHAT scores above as the scores are not the sole criteria for eligibility and review.
d. Case management services may continue if the CHAT score is above 25. Service continuation will be dependent upon clinical information submitted.

☒ Target group includes individuals transitioning to a community setting and are consistent with all federal guidelines. Case management services will be made available for up to 30 consecutive days of a covered stay in a medical institution. Reimbursement is made to community-based case managers and not the medical institution for this service. The target group does not include individuals between ages 22 and 64 who are served in Institution for Mental Disease or Individuals who are inmates of public institutions). (State Medicaid Director Letter (SMDL), July 25, 2000).

Areas of State In which services will be provided 1§1915(g)(1) of the Act):

☒ Entire State
☐ Only in the following geographic areas: **[Specify areas]**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

☐ Services are provided in accordance with §1902(a)(10)(B) of the Act.
☒ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, In gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

❖ Comprehensive assessment and periodic reassessment of Individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include

- taking client history;
- identifying the individual's needs and completing related documentation; and
- gathering information from other sources such as family members, medical

[Members with Developmental Disabilities]

providers, social workers, and educators (If necessary), to form a complete assessment of the eligible individual;

The comprehensive assessment must be completed within the first thirty (30) days of Initiation of services and reassessment must minimally occur on an annual basis (or as a change in the member's needs occur).

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address Identified needs and achieve goals specified in the care plan; and

- ❖ Monitoring and follow-up activities are consistent with federal regulations and include:
  - activities and contacts that are necessary to ensure the care plan is implemented

and adequately addresses the eligible Individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary. **Plans must be monitored at least every 90 days, or as the member's needs change and any change in the plan must be documented in the member's file.** Monitoring will be conducted to determine whether the following conditions are met:

- o services are being furnished in accordance with the Individual's care plan;
- o services in the care plan are adequate; and
- o changes in the needs or status of the Individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

☒Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible Individual access services; Identifying needs and supports to assist the

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eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and CFR 441.18(b)):

Provider qualifications are as follows:

Staff Qualifications
Comprehensive Case Manager Qualifications
a. Staff must have a minimum of a:

1. Bachelor's Degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing or closely related field,'

OR

2. Graduate of an accredited graduate school with a Master's Degree in social work, education, psychology, counseling, nursing or closely related field,

OR

3. Bachelor's Degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one (I) year of full-time equivalent relevant human services experience,

OR

4. Staff who were employed at the time this rule goes into effect (8/1/2009) as a case manager providing services under the former subsections will be considered qualified.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an Individual's free choice of providers In violation of section 1902(a)(23) of the Act.

1. Eligible Individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible Individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
☐ Target group consists of eligible Individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: **[Identify any limitations to be Imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive**

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needed services.]

Access to Services 42 CFR 441.18(a)(2). 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management)services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.(8)(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (I)The name of the Individual; (ii) The dates of the case management services; (Ill) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified In the care plan have been achieved; (v) Whether the Individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an Integral and Inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) Is not available in expenditures for, services defined In §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible Individual has been referred, Including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption

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[Members with Developmental Disabilities]

placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that Is Included In an Individualized education program or individualized family service plan consistent with § 1903(c) of the Act. (§§ 1902(a)(25) and 1905(c))
[Specify any additional limitations.]

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[Members in Protective Services of DHHS]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9))

Adults in Protective Custody must meet the specific eligibility requirements as follows:

Has attained the age of 18 years or is a legally emancipated minor; and a request or referral or nomination of guardianship or conservatorship has been submitted to the Office of Elder Services.

Children in Protective Custody must meet the specific eligibility criteria:

A child is under the age of eighteen (18) and is abused or neglected, or is suspected to be at risk of abuse or neglect; AND either a request or referral for investigation of suspected child abuse or neglect is submitted to the Office of Child and Family Services; OR
A child or young adult under age twenty-one (21) if the individual is either in the custody of the Department of Health and Human Services or of an agency in another State pursuant to a court order, or is in voluntary care of the Department or an agency in state pursuant to a written agreement or is a family receiving post-adoption services or services provided within a Private Non-Medical Institution, as defined in Section 97, Private Non-Medical Institutions, of the MaineCare Benefits Manual.

☒Target group Includes individuals transitioning to a community setting and are consistent with all federal guidelines. Case-management services will be made available for up to 30 days consecutive days of a covered stay in a medical institution. Reimbursement is made to community-based case managers and not the medical institution for this service. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public Institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Coverage and reimbursement of case management services for the protective services target group will cease on November 1, 2011.

Areas of State in which services will be provided (§1915)(g)(1) of the Act):
☒Entire State
☐Only in the following geographic areas: **[Specify areas]**

Comparability of services 1902(a)(10)(B) and 1915(g)(1))
☐Services are provided in accordance with §1902(a)(10)(B) of the Act.
☒Services are not comparable in amount duration and scope (§1915(g)(1)).

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[Members in Protective Services of DHHS]

Definition of services 42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, In gaining access to needed medical, social, educational and· other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities Include
  - taking client history;
  - identifying the Individual's needs and completing related documentation; and ·
  - gathering Information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

The comprehensive assessment must be completed within the first thirty (30) days of initiation of services and reassessment must minimally occur on an annual basis (or as a change in the member's needs occur).

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the Individual (or the Individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities are consistent with federal regulations and include:
  activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the Individual, family members, service providers, or other entities or Individuals and conducted as frequently as necessary. **Plans must be monitored at least every 90 days, or as the member's needs change and any**

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change in the plan must be documented in the member's file.

Monitoring will be conducted to determine whether the following conditions are met:

- services are being furnished in accordance with the individual's care plan;
- services in the care plan are adequate; and
- changes in the needs or status of the individual are reflected in the care plan.

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers

☒ Case management includes contacts with non-eligible individuals that are directly related to Identifying the eligible Individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible Individual's needs.
(42 CFR 440.169(e))

Targeted Case Management Services for Members involved with protective/social welfare services are provided following a determination of the medical necessity for the services. The State Medicaid Agency determines the medical necessity for these services. Targeted Case Management services are provided after a determination that they are necessary to prevent, alleviate, prevent the worsening of or correct conditions that endanger life, cause suffering or pain, result in illness, Interfere with a person's capacity for normal activity.

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b))
Provider qualifications are as follows:

Staff Qualifications
Comprehensive Case Manager Qualifications
a. Staff must have a minimum of a:

1. Bachelor's Degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing or closely related field,'
   OR
2. Graduate of an accredited graduate school with a Master's Degree in social work, education, psychology, counseling, nursing or closely related field,
   OR
3. Bachelor's Degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one (I) year of full-time equivalent relevant human services experience,

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OR

4. Staff who were employed at the time this rule goes into effect (8/1/2009) as a case manager providing services under the former subsections will be considered qualified.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict a individual's free choice of providers In violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area Identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915)(g)(1) and 42 CFR 441.18(b)):
☐Target group consists of eligible Individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: **[Identify any limitations to be Imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the Individual; (ii) The dates of the case

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management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the Individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an Integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available In expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an Individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

[Specify any additional limitations.]

Coverage and reimbursement of case management services for the protective services target group will cease on November 1, 2011.

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[Adults with Substance Abuse Disorders]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Adults with Substance Abuse Disorders must meet the specific eligibility requirements as follows:

1. An adult who has an Axis I diagnosis(es) of substance abuse disorder(s) described in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) AND
2. Who is currently seeking substance abuse treatment services by a DHHS approved substance abuse treatment provider; AND
3. Who is pregnant, who is living with his or her minor children, and/or who is an intravenous drug user, AND
4. Who is enrolled in a substance abuse program which receives funding by the Substance Abuse Prevention Treatment Block Grant as provided by 42 U.S.C. section 300x-22(b).

☒ Target group includes individuals transitioning to a community setting and are consistent with all federal guidelines. Reimbursement Is made to community-based case managers and not to the medical institution for this service. Case-management services will be made available for up to thirty (30) consecutive days of a covered stay in a medical institution. The target group does not include Individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000).

Areas of State in which services will be provided (§1915(g)(1) of the Act):

☒ Entire State
☐ Only in the following geographic areas: **[Specify areas]**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

☐ Services are provided in accordance with §1902(a)(10)(B) of the Act.
☒ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist Individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

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- Comprehensive assessment and periodic reassessment of Individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

The comprehensive assessment must be completed within the first thirty (30) days of Initiation of services and reassessment must minimally occur on an annual basis (or as a change in the member's needs occur).

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the Individual;
  - Includes activities such as ensuring the active participation of the eligible individual, and working with the Individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- Monitoring and follow-up activities are consistent with federal regulations and include:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible Individual's needs, and which *may* be with the Individual, family members, service providers, or other entitles or individuals and conducted as frequently as necessary. Plans must be monitored at least every 90 days, or as the member's needs change and any change in the plan must be documented in the member's file. Monitoring will be conducted to determine whether the following conditions are met:
  - services are being furnished In accordance with the individual's care plan;
  - services In the care plan are adequate; and
  - changes in the needs or status of the Individual are reflected In the care

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plan.

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

☒ Case management includes contacts with non-eligible Individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible Individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Provider qualifications are as follows:

Staff Qualifications
Comprehensive Case Manager Qualifications

a. Staff must have a minimum of a:
   1. Bachelor's Degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing or closely related field,
      OR
   2. Graduate of an accredited graduate school with a Master's Degree in social work, education, psychology, counseling, nursing or closely related field,
      OR
   3. Bachelor's Degree from an accredited four(4) year institution of higher learning in an unrelated field and at least one (1) year of full-time equivalent relevant human services experience,
      OR
   4. Staff who were employed at the time this rule goes into effect (8/1/2009) as a case manager providing services under the former subsections will be considered qualified.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers In violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible Individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

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[Adult with Substance Abuse Disorders]

☐ Target group consists of eligible Individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental

disabilities or with chronic mental illness receive needed services: **[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not tie compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the Individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A time line for reevaluation of the plan.

Limitations:
Case management does not Include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined In §440.169 when the case management activities are an integral and Inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not

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available In expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other

services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or Interviewing potential foster care parents; serving legal papers;

home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that Is Included In an Individualized education program or Individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))
[Specify any additional limitations.]

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F. The State assures that the **provision** of case management services will not restrict an individual's free choice of providers in violation of section 1902(A)(23) of the Act.

1. Eligible recipients will have free choice of providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payments for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.